

ACUTE FLACCID PARALYSIS INITIAL QUESTIONNAIRE (Revised May 2015)
Australian Paediatric Surveillance Unit – Victorian Infectious Diseases Reference Laboratory

Please keep a record of the child's unit number in your APSU folder.

Enquires Dr Bruce Thorley at VIDRL ph: (03) 9342 9607 to discuss this questionnaire or Prof Elizabeth Elliott on (02) 9845 3005 for clinical queries.

Please return questionnaire in the addressed reply-paid envelope to: AFP Surveillance, Victorian Infectious Diseases Reference Laboratory, The Doherty Institute,
792 Elizabeth Street, Melbourne, Victoria 3000 fax: (03) 9342 9665 email: enterovirus@mh.org.au

FOR INFORMATION REGARDING REFERRAL OF SPECIMENS TO VIDRL PLEASE SEE <http://www.vidrl.org.au/surveillance/afp-surveillance/>

If this patient is primarily cared for by another physician who you believe will report the case, please complete the reporting clinician and patient details only and return to VIDRL. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

The primary clinician caring for this child is: **Name:** _____

Hospital: _____

REPORTING CLINICIAN'S DETAILS

1. APSU Dr Code 2. Month/Year of Report /
3. Dr Name _____ 4. Dr Address _____
5. Dr Telephone (0) _____ Fax: (0) _____ Email _____

PATIENT DETAILS

6. First 2 letters of Surname 7. First 2 letters of Given Name 8. Hospital Of Admission _____
9. Date of Birth: / / 10. Sex M ☐ F ☐
11. Postcode 12. Of Aboriginal/Torres Strait Islander descent? ☐ Yes ☐ No ☐ Unsure

PATIENT VACCINATION HISTORY

13. Has the patient ever been immunised with a vaccine including polio? ☐ Yes ACIR/written record; ☐ Yes self-report; ☐ No ☐ Unknown
14. Number of doses? _____ If known, date of last dose? Date /...../...../..... ☐ Unknown
15. Has the patient been in contact with someone who received oral polio vaccine within the 6 weeks prior to onset of symptoms? ☐ Yes ☐ No ☐ Unsure
16. Has the child travelled overseas in the last 3 months? ☐ Yes ☐ No ☐ Unsure. IF YES, specify where _____
17. Has the patient had contact with anyone who has travelled overseas OR visited from overseas in the last 3 months? ☐ Yes ☐ No ☐ Unsure.
IF YES, specify country of travel or origin and relationship to patient _____
18. In the 4 weeks prior to presentation did the child;
a) receive influenza vaccine? ☐ Yes ☐ No ☐ Unsure IF YES, type of vaccine: _____ Date given...../...../.....
b) have a laboratory proven influenza-like illness? ☐ Yes ☐ No ☐ Unsure IF YES, type of illness: _____ Date of positive specimen...../...../.....

CLINICAL FEATURES & INVESTIGATIONS

19. Date of onset of paralysis (dd/mm/yy) 18. Site of paralysis _____
20. Was the patient hospitalised? ☐ Yes ☐ No ☐ Unsure
21. Was the patient immunosuppressed? ☐ Yes ☐ No ☐ Unsure IF YES, specify _____
22. Was a sensory level detected on examination? ☐ Yes ☐ No ☐ Unsure IF YES, specify _____
23. Was there cranial nerve involvement? ☐ Yes ☐ No ☐ Unsure IF YES, specify _____
24. Was there bladder and/or bowel involvement?
(eg. Urinary retention/incontinence) ☐ Yes ☐ No ☐ Unsure IF YES, specify _____
25. Was a lumbar puncture done? ☐ Yes ☐ No ☐ Unsure
26. IF YES, CSF: protein _____g/L glucose _____mmol/L Number of _____PMN _____Lymphocyte _____RBC; other _____
27. Were nerve conduction studies done? ☐ Yes ☐ No ☐ Unsure IF YES, specify results _____
28. Was an MRI done? ☐ Yes ☐ No ☐ Unsure IF YES, brain ☐ or spinal ☐
If YES, specify findings _____
29. Was an EMG performed? ☐ Yes ☐ No ☐ Unsure
If YES, specify findings _____
30. How many faecal specimens were sent for viral culture? ☐ None ☐ One ☐ Two ☐ Unsure

DIAGNOSIS

31. In light of currently available evidence, what is the patient's diagnosis? (Please indicate on list below)

Peripheral neuropathy	Acute myelopathy	Systemic disease
<input type="checkbox"/> Guillain-Barré syndrome (acute post- infectious polyneuropathy)	<input type="checkbox"/> Transverse myelitis	<input type="checkbox"/> Acute porphyria
<input type="checkbox"/> Acute axonal neuropathy	<input type="checkbox"/> Acute disseminated encephalomyelitis (ADEM)	<input type="checkbox"/> Critical illness neuropathy/ myopathy
<input type="checkbox"/> Neuropathies of infectious diseases	<input type="checkbox"/> Spinal cord ischaemia	<input type="checkbox"/> Conversion disorder
<input type="checkbox"/> Acute toxic neuropathies(heavy metals)	<input type="checkbox"/> Spinal cord injury or compression eg. Tumour, trauma	Disorders of neuromuscular transmission
<input type="checkbox"/> Focal mononeuropathy	<input type="checkbox"/> Peri-operative complication	<input type="checkbox"/> Botulism
Anterior horn cell disease	Muscle disorders	<input type="checkbox"/> Insecticide e.g. organophosphate poisoning
<input type="checkbox"/> Acute poliomyelitis	<input type="checkbox"/> Polymyositis, dermatomyositis	<input type="checkbox"/> Tick bite paralysis
<input type="checkbox"/> Vaccine-associated poliomyelitis	<input type="checkbox"/> Periodic paralyses	<input type="checkbox"/> Myasthenia gravis
<input type="checkbox"/> Other neurotropic viruses	<input type="checkbox"/> Mitochondrial diseases (infantile type)	<input type="checkbox"/> Snake bite
	<input type="checkbox"/> Viral myositis	Other (specify) _____
	<input type="checkbox"/> Drug-induced paralysis (specify) _____	

OUTCOME

32. Did the patient survive the illness? ☐ Yes ☐ No ☐ Unsure IF NO, please give number of days between onset of paralysis and death days
33. Does the patient have any residual paralysis? ☐ Yes ☐ No ☐ Unsure IF NO, duration of paralysis? days
34. If YES, specify level sensory _____ motor _____
35. Is there residual sphincter dysfunction? ☐ Yes ☐ No ☐ Unsure

Thank you for contributing to AFP surveillance and the WHO polio eradication program
PLEASE USE THE BACK OF THIS QUESTIONNAIRE IF YOU HAVE ANY FURTHER INFORMATION THAT MAY HELP US